Statement of Kentuckians for Single Payer Health Care to the Ways and Means Committee Hearing on Pathways to Universal Health Care

We thank Chairman Neal for scheduling this hearing, boldly calling on members of the Committee and those giving testimony to propose solutions to the problems of a health care system in crisis—a system that costs far too much yet leaves millions to suffer needlessly for lack of care.

Our organization has been working since 2004 to bring Kentuckians together to push for a national health program that will solve this crisis for our state and for the nation. We have worked since that time to educate ourselves, communities across the state, office holders, and candidates on sound health care policy that can bring high quality care to everyone.

With this testimony we share what we have learned, and we urge the Committee to act upon it to enact a national single payer health care system, an improved and expanded Medicare for All as spelled out in the plan of the Physicians' for a National Health Program (PNHP).[1]

Marcia Angell, MD, former Editor of the New England Journal of Medicine, has pointed out that that we cannot simultaneously (a) increase care and (b) cut costs unless we change to a single payer system that removes the profits and the insurance companies.[2] Under our current health care system, all efforts to rein in the costs result in cuts to care. Plans designed to cover more people and improve care end up dramatically increasing the costs.

That opposite movement of cost and care informs us that as long as the profits of the insurance companies and investor-owned facilities are involved in health care, we cannot improve and expand the care without costing us more than our already outrageously expensive annual health care bill.

That was an extremely important lesson to learn, for the U. S. spends about double, per capita, what the other industrialized countries spend, yet we still rank 56th in the world in infant mortality and 43rd in life expectancy.[3] The US spends annually over $11,500 per capita, about 18% of GDP, on health care, but our outcomes are comparatively low in many standard measures of health care effectiveness, and tragically, when deaths from conditions amenable to treatment[4] are counted, the US results are shocking.

Therefore, we urge the committee to adopt the PNHP proposal as the basis of the solution. The PNHP plan proposes a publicly financed National Health Program that would fully cover everyone for all necessary medical care while lowering costs by eliminating the profit-driven private insurance industry with its massive overhead.

With this proposal, hospitals, nursing homes, and other provider facilities would be non profit; they would be paid using global operating budgets rather than fees for each service. Physicians could opt to be paid on a fee for service basis or by salaries in facilities paid by global budgets.

Because investor ownership of health care providers is known to compromise quality and divert funds from clinical care to overhead and profits, the proposal would not include such providers.

Here are the essential elements, briefly summarized, of the PNHP proposal:

1. Coverage

Everyone would be covered for all medically necessary services, including mental health, rehabilitation, long term care and dental care without copayments or deductibles. Cost sharing by patients is ineffective at containing costs and blocks or delays vital care, reduces adherence to medications, and selectively burdens the sick and the poor.

The plan, like Medicare would ban private insurance that duplicates the public coverage. This prevents a two-tiered system and inclusion of the affluent assures good coverage.

2. Hospital Payment

Global budgets would be negotiated annually and would cover operating expenses but not expansion or modernization which would be funded separately through capital allocations. For-profit hospitals would be converted to nonprofit governance, and their owners compensated. These budgets would mostly eliminate hospital billing and relieve clinicians of billing-related documentation and free resources to enhance clinical services.

3. Payment for Physicians and Outpatient Care

Physicians would be paid fee-for-service or salaried through the global budgets of the facilities where they work. The plan would prohibit diversion of operating revenues to profits or capital investments and the payment of bonuses tied to utilization or to institutional profitability. The plan would shrink physicians' overhead expenses by simplifying or eliminating billing-related tasks. Practitioners would negotiate with the plan for a binding fee schedule.

4. Long-Term Care

The plan would fund the full spectrum of long-term care and services for the disabled of all ages. The plan would emphasize that care be provided in patients' homes and communities rather than institutions.

5. Health Planning and Explicit Capital Funding

The plan would fund capital investments through explicit appropriations. When capital funding and operating payments are combined in a single revenue stream, as is currently the case, profitable institutions are able to expand and modernize, regardless of medical need while those with less favorable bottom lines fall behind. Profitability often reflects not efficiency or quality but the avoidance of unprofitable patients and services and a willingness to game the payment systems.

6. Medications, Devices, and Supplies

The plan would cover all medically necessary prescription medications, devices and supplies. It would directly negotiate prices with manufacturers, producing substantial savings.

Full drug coverage with no copayments is an essential component of the plan. Copayments reduce adherence to medications and worsen clinical outcomes. The plan would use its market clout and formularies to negotiate lower drug prices with manufacturers. Currently the Veterans Administration pays only 56-63% as much as Medicare does for drugs because Medicare is prohibited from negotiating for lower prices.

7. Cost Containment

The plan would trim administration, reduce incentives to over-treat, lower drug prices, minimize investments in redundant facilities, and eliminate marketing and investor profits. These measures would yield the savings needed to fund universal care while improving care for those currently covered. It will also fund new investments in under-funded services and public health. The plan would not cause any net increase in national health spending.

Because private insurers' overhead currently averages 12% as compared with only about 2.1% for traditional Medicare, the savings would reduce administrative costs to Canadian levels saving over $400 billion annually.

8. Funding

Total expenditures under the plan would be limited to approximately the same proportion of GDP as the year prior. The plan favors the use of progressive taxes in order to reduce income inequality. During a transition period, all public funds currently spent on health care would be redirected to the health care budget.

Additional funds would be raised through progressive taxes which would be fully offset by a decrease in out-of-pocket spending and premiums.

Proposals other than national single payer health care cannot curtail the costs and expand the care

There is a proposal to simply keep and/or expand the Affordable Care Act. But the Affordable Care Act leaves 30 million uninsured while denying care to many who have coverage but cannot afford the copays and deductibles. Bronze plans cover only about 60% of enrollees' expenses with out of pocket costs on top of premiums as high at $13,200 annually.

Accountable Care Organizations (ACO's) have been proposed as a solution but they do not show the savings nor improvement in care they claim. The ACO's involve risk of profit or loss for physicians and hospitals. ACO's are a gaping loophole for insurance company criteria to re-enter health care and destroy a sound single payer system.

"Value-based payment" and "pay for performance" are supposed to contain costs and improve outcomes, yet that assertion is based on dubious assumptions about measurement and motivation.

These misguided efforts require massive administrative work on the part of physicians, yet they cannot accurately measure value. They punish the facilities and physicians who serve the neediest and deepen racial discrimination. They are a major cause of physician burn-out.

Medicare buy-ins and public options should be abandoned before they are started. Because they maintain the profits and the insurance companies, they cannot control the costs and expand the care.[5]

Kentuckians for Single Payer Health Care urges the committee to start with HR 1384. It is the only current legislation that begins with a single payer foundation. Then the committee should amend the bill to bring it into conformity with the PNHP proposal so that we can begin from sound, model, practical, effective legislation. Let us not begin the discussion from a severely compromised bill.

The elements that should be added to HR 1384 are those that were contained in HR 676, the Expanded and Improved Medicare for All legislation that was introduced into each Congress from 2003 through 2017 and had more cosponsors than HR 1384 does now.

1. The for-profit hospitals and other institutions must be banned from the system. They clearly give lower quality care yet cost more.[6]

So add this provision from HR 676 of 2017 to HR 1384:

SEC. 103. Qualification of participating providers.

(a) Requirement To be public or non-Profit.—

(1) IN GENERAL.—No institution may be a participating provider unless it is a public or not-for-profit institution. Private physicians, private clinics, and private health care providers shall continue to operate as private entities, but are prohibited from being investor owned.

(2) CONVERSION OF INVESTOR-OWNED PROVIDERS.—For-profit providers of care opting to participate shall be required to convert to not-for-profit status.

(3) PRIVATE DELIVERY OF CARE REQUIREMENT.—For-profit providers of care that convert to non-profit status shall remain privately owned and operated entities.

(4) COMPENSATION FOR CONVERSION.—The owners of such for-profit providers shall be compensated for reasonable financial losses incurred as a result of the conversion from for-profit to non-profit status.

2. The funding of the system must be progressive. HR 1384 is missing any indication as to how the funds will be raised. The outline of the additional funding from HR 676 of 2017 should be added to HR 1384.

SEC. 211. Overview: funding the Medicare For All Program. …

(c) Funding.—

(1) IN GENERAL.—There are appropriated to the Medicare For All Trust Fund amounts sufficient to carry out this Act from the following sources:

(A) Existing sources of Federal Government revenues for health care.

(B) Increasing personal income taxes on the top 5 percent income earners.

(C) Instituting a modest and progressive excise tax on payroll and self-employment income.

(D) Instituting a modest tax on unearned income.

(E) Instituting a small tax on stock and bond transactions.

3. Because a national single payer, improved Medicare for All system will save by removing administrative waste, the program must provide for the workers who will be displaced. It is important to add to HR 1384, the provision from HR 676 that assures that displaced workers are guaranteed two years of their annual salary up to $100,000 per year. Here is the provision from the HR 676 of 2017:

SEC. 303. Regional and State administration; employment of displaced clerical workers.

… (e) First priority in retraining and job placement; 2 years of salary parity benefits.—The Program shall provide that clerical, administrative, and billing personnel in insurance companies, doctors offices, hospitals, nursing facilities, and other facilities whose jobs are eliminated due to reduced administration—

(1) should have first priority in retraining and job placement in the new system; and

(2) shall be eligible to receive two years of Medicare For All employment transition benefits with each year's benefit equal to salary earned during the last 12 months of employment, but shall not exceed $100,000 per year.

(f) Establishment of Medicare For All employment transition fund.—The Secretary shall establish a trust fund from which expenditures shall be made to recipients of the benefits allocated in subsection (e).

(g) Annual appropriations to Medicare For All employment transition fund.—Sums are authorized to be appropriated annually as needed to fund the Medicare For All Employment Transition Benefits.

(h) Retention of right to unemployment benefits.—Nothing in this section shall be interpreted as a waiver of Medicare For All Employment Transition benefit recipients' right to receive Federal and State unemployment benefits.

4. Remove Title X of HR 1384 which provides for a transitional period of improvement in Medicare benefits while the insurance companies still control health care and then provides for a Medicare buy-in. Such provisions harm rather than help with the transition.

Medicare is clearly constitutional; so is a national single payer health system, an improved Medicare for All. The Medicare buy-in in HR 1384 would increase costs while not yet harvesting the savings of the single payer plan. It therefore endangers single payer rather than helps.

Medicare was implemented within 10 months in the era prior to computerization. Improved Medicare for All can be implemented in a similar way. The PNHP plan changes the financing system leaving in place the current elements of the delivery system. A Medicare-buy-in or public option must be avoided as detrimental.[7]

HR 1384 with the addition of the four above amendments is the place from which to begin the discussion of universal health care. HR 676 in the 115th Congress had 124 cosponsors and was popular across the country. By adding these four provisions to HR 1384, the Ways and Means Committee can best put forward the sound, effective, data-driven health care plan that the people of our nation deserve.

The US has the opportunity to create the best health care system in the world. This Committee should adopt the PNHP proposal as the starting point and move us forward to a national single payer health care system, an improved Medicare for All.

1. https://pnhp.org/what-is-single-payer/physicians-proposal/

2. https://prescriptions.blogs.nytimes.com/2009/08/12/questions-for-dr-marcia-angell/

3. https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html

4. https://www.healthsystemtracker.org/chart-collection/mortality-rates-u-s-compare-countries/#item-amenable-mortality-2004-and-2014

5. https://pnhp.org/what-is-single-payer/faqs/#what-about-adding-a-public-option-or-medicare-buy-in-to-the-aca

6. https://www.healthaffairs.org/do/10.1377/hblog20181116.732860/full/

7. https://pnhp.org/what-is-single-payer/faqs/#what-about-adding-a-public-option-or-medicare-buy-in-to-the-aca

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